## PART I: STUDENT AND ACADEMIC INFORMATION

<table>
<thead>
<tr>
<th>Last name or Family name</th>
<th>First name</th>
<th>Middle</th>
<th>Relationship to student</th>
<th>Phone number of Emergency Contact (with area code)</th>
</tr>
</thead>
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</tr>
</tbody>
</table>

**Today's Date (mm/dd/yyyy)**  
**VALPO Student ID (7 digit number)**  
**Date of Birth (mm/dd/yyyy)**

**Local Address**

**Emergency Contact - Name**  
**First term attending and year of enrollment:** Fall 20____ Winter 20____ Spring 20____ Summer 20____

**Indicate your academic class:**  
____ Undergraduate  ____ Graduate  ____ Law  ____ International  ____ InterLink

**I will be enrolled:**  
____ Part-Time  ____ Full-Time

**Full-time = Undergraduate student ≥12 credit hours and Graduate student ≥9 credit hours, per semester term**

**Are you a NCAA athlete?**  
____ Yes  ____ No  
**Will you be living on campus?**  
____ Yes  ____ No

**Have you ever or are you currently serving in the US armed forces?**  
____ Yes  ____ No

## HEALTH INSURANCE INFORMATION:

**On an annual basis,** if you are registered as a FULL-TIME STUDENT or a LAW STUDENT you will be enrolled in the university sponsored insurance, currently offered through UnitedHealthcare StudentResources (UHCSR) and you will be billed for the cost of the premium. **If you do NOT want this University plan, you must have your own active qualified health insurance plan and you must decline the University plan by waiving out of the insurance during the waive out period.** The website you need to access to waive out of this plan is [https://studentcenter.uhcsr.com/valpo](https://studentcenter.uhcsr.com/valpo) and you need to complete the waive out process 1 to 2 months prior to the first day of class. **PROVIDING THE INFORMATION BELOW DOES NOT WAIVE YOU OUT OF THE UNIVERSITY SPONSORED INSURANCE PLAN.** Please provide your insurance information below:

<table>
<thead>
<tr>
<th>Insurance Company: Name</th>
<th>Mailing Address of Ins. Co.</th>
<th>Phone Number of Ins. Co.</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy Holder's Name</th>
<th>Date of Birth of Policy Holder</th>
<th>Policy Number</th>
<th>Group Number</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

### Deadline for Mailing the Health Record Form

Students accepted after the term deadline listed below have 30 days from date of acceptance to complete this form.

<table>
<thead>
<tr>
<th>Fall Semester Deadline</th>
<th>Instructions – Read prior to completing this form</th>
<th>Spring Semester Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1</td>
<td></td>
<td>December 1</td>
</tr>
</tbody>
</table>

1. **Valparaiso Student** – All full-time undergraduate, graduate, and all law students are required to complete Parts I, III, IV and V. If under 18 years of age, also complete Part V and VI with your parent/guardian.

2. **Proof of Immunization** – Provide proof of immunizations by submitting one of the following:

   - Part II Required Immunizations (page 2) must be completed, signed, and dated by a healthcare professional.
   - Submit a copy of your immunization records from your physician, former high school or university, or other official immunization records. Any paperwork must list all required immunizations.

3. **No Immunization Record** – If you have no immunization records, you have the option to complete blood tests to prove immunity or to be re-vaccinated.

4. **Penalty** – Students who fail to submit the completed Student Health Form, including proof of immunizations and fail to rectify deficiencies within 30 days after the start of classes will be:

   - Held from class registration for subsequent terms until compliant in accordance with the State of Indiana.
   - **PROVIDING THE INSURANCE INFORMATION BELOW DOES NOT WAIVE YOU OUT OF THE UNIVERSITY SPONSORED INSURANCE PLAN. YOU ARE STILL REQUIRED TO WAIVE OUT ON-LINE IF YOU ARE REGISTERED AS FULL-TIME OR A LAW STUDENT, ANNUALLY. ANY QUESTIONS PLEASE VISIT valpo.edu/healthcenter OR CALL 219.464.5400.**

5. **Completed Forms** – Mail to Valparaiso University Student Health Center, 55 University Drive, Suite 102, Valparaiso, IN 46383

6. **Communication** – The student's email address will be used to communicate any and all health form, immunization, or insurance deficiencies.
PART II: REQUIRED IMMUNIZATIONS
FULL-TIME/LAW STUDENTS

All full-time and law students are required by Valparaiso University and the State of Indiana to submit proof of immunizations. THIS PAGE MUST BE COMPLETED BY A HEALTHCARE PROVIDER (e.g. MD, DO, NP, PA or RN), and include their name (printed), phone number, signature and date at the bottom, to be considered valid under Indiana State Law. Dates of vaccinations are required.

Submit a copy of your immunization records from your physician, former high school or university, or other official immunization records. Any paperwork must list all required immunizations.

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Valpo Student ID:</th>
<th>Date of Birth:</th>
</tr>
</thead>
</table>

Students born prior to 1/1/1957 are NOT required to submit immunization records - enclose a copy of your driver's license instead of this page.

### M-M-R (COMBINED Measles, Mumps, Rubella) vaccination

- If given separately, complete section below instead.
- CDC/ACIP recommends 2 doses of MMR.

<table>
<thead>
<tr>
<th>MEASLES (Rubella)</th>
<th>MUMPS</th>
<th>RUBELLA (German Measles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 doses required. Both must be done on or after 1st birthday, after 1/1/68, and at least 28 days apart.</td>
<td>1 dose required on or after 1st birthday.</td>
<td>2 doses required. Both must be done on or after 1st birthday, after 1/1/68, and at least 28 days apart.*</td>
</tr>
<tr>
<td>Date #1: <em><strong>/</strong>__/</em>______</td>
<td>Date: / /_____</td>
<td>Date #1: <em><strong>/</strong>__/</em>______</td>
</tr>
<tr>
<td>Date #2: <em><strong>/</strong>__/</em>______</td>
<td>OR - Date of illness: / /_____</td>
<td>Date #2: <em><strong>/</strong>__/</em>______</td>
</tr>
<tr>
<td>OR - Date of illness: / /_____</td>
<td>OR - Attach copy of lab report (titer) confirming immunity (antibodies).</td>
<td>OR - Attach copy of lab report (titer) confirming immunity (antibodies).</td>
</tr>
</tbody>
</table>

### TETANUS/DIPHTHERIA BOOSTER (Td or Tdap meet the requirement)

- Must be within 10 years prior to entrance into Valparaiso University.
- CDC/ACIP recommends Tdap if not received since 2006.

### TUBERCULOSIS – Complete Part III: Tuberculosis Self-Screening on page 3 to determine if tests are needed. If your answers to the Tuberculosis Self-Screening instruct you to complete a TB test and you complete a PPD skin test, record the result here.

- * If result is >= 10mm, refer to Instruction Set B of the Tuberculosis Self-Screening for additional requirements.

### RECOMMENDED (NOT REQUIRED):

- MENINGOCOCCAL QUAD (MMRV4 or ACWY) - Date: #1 ___/____/_______ Date #2: ___/____/_______ and
- MENINGOCOCCAL B (MenB-4C or Bexsero)- Date #1: ___/____/_______ Date #2: ___/____/_______
- OR (Men-FHbp or Trumenba) - Date #1: ___/____/_______ Date #2: ___/____/_______
- Date #3: ___/____/_______

### VACCINATIONS REQUIRED (NOT REQUIRED):

- VARICELLA* (Chicken pox) - Date #1: ___/____/_______ Date #2: ___/____/_______ Date of Illness: ___/____/_______
- HEPATITIS B* - Date #1: ___/____/_______ Date #2: ___/____/_______ Date #3: ___/____/_______
- HEPATITIS A - Date #1: ___/____/_______ Date #2: ___/____/_______
- HPV (Human Papillomavirus) - Date #1: ___/____/_______ Date #2: ___/____/_______ Date #3: ___/____/_______
- *OR - Attach copy of lab report (titer) confirming immunity (antibodies)

### SUBMIT DOCUMENTATION TO THE VALPARAISO STUDENT HEALTH CENTER! Failure to do so will result in a registration hold.

**Healthcare Provider:** By signing below, you attest that all information supplied in this section is true and correct to the best of your knowledge.

Name and title of Provider (printed): ____________________________

Signature of Provider: ____________________________ Date: ___/____/_______

Phone Number: _________

Exemptions: If you feel that you are exempt from vaccination requirements based on a medical contraindication, religious belief, or pregnancy, please contact Valparaiso University Student Health Center at 219.464.5060 to discuss the necessary procedures and documentation.
PART III: TUBERCULOSIS SELF-SCREENING (completed by student)

NOTE: THIS SCREENING IS REQUIRED FOR DOMESTIC FULL-TIME & ALL LAW STUDENTS ONLY

Student Name: ___________________________ Student ID: __________________ Date of Birth: __________________

Begin with the 1st question and circle the appropriate response. If you answer “NO”, proceed to the next question until all questions are answered. If you answer “YES” to any question, proceed to Instruction Set A or B as directed. Once you answer “YES” to a question, do not answer the remaining questions.

1. Do you currently have any of the following unexplained or undiagnosed symptoms: fever or chills, unexplained weight loss, loss of appetite, swollen lymph nodes, persistent night sweats, persistent cough for greater than 1 month? If “YES”, contact your healthcare provider immediately. Follow Instruction Set “A” below. YES NO

2. Have you ever been diagnosed with tuberculosis? IF “YES”, follow Instruction Set “B” below. YES NO

3. Have you ever had a positive skin test (PPD) or positive TB blood test? IF “YES”, follow Instruction Set “B” below. YES NO

4. In the last year, have you lived or traveled anywhere other than the countries listed below for a period longer than 1 month? IF “YES”, follow Instruction Set “A” below. YES NO

Albania, American Samoa, Andorra, Antigua & Barbuda, Aruba, Australia, Austria, Bahamas, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Japan, Jordan, Lebanon, Luxembourg, Macedonia, Malta, Monaco, Montserrat, Montenegro, Netherlands, New Caledonia, New Zealand, Norway, Oman, Puerto Rico, St. Kitts & Nevis, St. Lucia, Slovakia, Slovenia, Samoa, San Marino, Spain, Sweden, Switzerland, Syrian Arab Republic, Tokelau, Tonga, United Arab Emirates, United Kingdom, United States, US Virgin Islands, West Bank & Gaza.

5. Do you currently have one or more of the following medical conditions listed below? IF “YES”, follow Instruction Set “A” below. YES NO

- IV Drug Use
- Abnormal immune system (including HIV/AIDS, cancer chemotherapy, etc.)

6. In the last year, have you worked, lived or volunteered in a hospital or other healthcare facility, homeless shelter, prison, nursing home, or HIV/AIDS clinic in a capacity where you had contact with patients and/or residents? IF “YES”, follow Instruction Set “A” below. YES NO

OR

Are you enrolled in the College of Nursing and Health Care Professions and in need of clinical clearance to practice in your clinical sites? IF “YES”, follow Instruction Set “A” below.

7. Have you had close contact with someone with active tuberculosis OR a medically underserved population which is at high-risk for tuberculosis? IF “YES”, follow Instruction Set “A” below. YES NO

IF YOU ANSWERED “NO” TO ALL OF THE QUESTIONS ABOVE, YOUR TUBERCULOSIS REQUIREMENT IS COMPLETE.

INSTRUCTION SET A: You are required to submit proof of a TB test that was performed within 6 months prior to entrance into Valparaiso University.

Acceptable TB tests include:

- TB skin test (PPD): Healthcare provider must supply date placed, date read and result in mm induration.
- Interferon-Gamma Release Assay (IGRA): Includes QuantiFERON® TB Gold or T-SPOT blood tests. A copy of the lab report must be attached.

PLEASE NOTE: If PPD result is >= 10mm or the blood test is positive; you are also required to follow INSTRUCTION SET B below.

INSTRUCTION SET B: You are required to 1) submit a report from a Chest X-Ray within 6 months prior to entrance into Valparaiso University, and 2) if treated for tuberculosis, a copy of any treatment, including medications and dates of treatment to the Student Health Center. Upon arrival to campus and after class registration is complete, you will also be required to meet with a Student Health Center Provider.
**PART IV: HEALTH HISTORY**

Student Name: ___________________________________________  Student ID: ______________________ Date of Birth: ______________________

**Personal Health History**

PLEASE CHECK YES OR NO (Y/N), PROVIDING SPECIFIC DETAILS TO ALL “YES” ITEMS TO THE BEST OF YOUR KNOWLEDGE.

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>ITEM</th>
<th>DETAILS (list specific information)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Will you be receiving allergy shots at Valpo?</td>
<td>If Yes, please complete the Allergy Packet found on SHC website valpo.edu/healthcenter and return completed forms to: Valparaiso Student Health Center 55 University Dr, Ste 102, Valparaiso, IN 46383</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do you have a history of allergies? (medication/food/seasonal)</td>
<td>List allergies:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do you take medication on a regular basis? (prescription and over-the-counter)</td>
<td>List name of medication dose and frequency: (ex. ibuprofen 200mg 2 tablet 2 times daily)</td>
</tr>
</tbody>
</table>

Recent: Height ______ ft. ______ in. Weight ______ lbs.

Which local pharmacy do you plan or prefer to use while at Valpo? (circle one)

CVS (located on Calumet)  CVS (located on Rt 30)  Fagen  Gil Drugs  Target  Walgreens (located on Calumet)  Walgreens (located on Rt 30)  Walmart

**Other surgical/medical condition not listed:**

__________

**Family Health History**

PLEASE CHECK YES OR NO (Y/N). Indicate relationship as follows for “Yes” items: F=Father, M=Mother, B=Brother, S=Sister

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Y</th>
<th>N</th>
<th>YEAR</th>
<th>Relationship</th>
<th>ITEM</th>
<th>Y</th>
<th>N</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol or drug problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Asthma</td>
<td></td>
<td></td>
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<tr>
<td>Smoking history</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Heart condition, disease, or murmur</td>
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<tr>
<td>Attention Deficit/Hyperactivity Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sleep disorders</td>
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<tr>
<td>Cancer, leukemia, or lymphoma</td>
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<td></td>
<td></td>
<td></td>
<td>Kidney disease or dialysis</td>
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<td></td>
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<tr>
<td>Thyroid disorders</td>
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<td></td>
<td></td>
<td></td>
<td>Heart condition, disease, or murmur</td>
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<tr>
<td>Cholesterol or lipid problems</td>
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<td></td>
<td></td>
<td>Migraine Heads</td>
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<tr>
<td>Concussion/Mild Traumatic Brain Injury</td>
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<td></td>
<td></td>
<td>Mononucleosis/Epstein-Barr Virus</td>
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<tr>
<td>Depression or Anxiety (specify)</td>
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<td></td>
<td></td>
<td>Stomach disorders or digestive issues</td>
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<tr>
<td>Diabetes Mellitus</td>
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<td></td>
<td>Anemia or blood disorders</td>
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<tr>
<td>Eating Disorder/Anorexia/Bulimia</td>
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<td></td>
<td>Tonsillectomy</td>
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<tr>
<td>Emotional/Psychological problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Appendectomy</td>
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<tr>
<td>Stroke, Heart attack, disease, or problem</td>
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<td></td>
<td></td>
<td></td>
<td>Skin disorders</td>
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</table>

**PART V: STUDENT SIGNATURE (REQUIRED)**

PERMISSION FOR TREATMENT: We hereby grant permission to the providers and medical staff of the Valparaiso University Student Health Center, and any hospital, medical, surgical, or psychiatric facility for treatment as deemed necessary by any one of them for the above named student. In addition, if I receive treatment at Porter Health Care System, Community Health Care System, or Franciscan Health Network while a student at Valparaiso University, I give Porter Health Care System, Community Health Care System, or Franciscan Health Network and all its departments consent for release of information to Valparaiso University Student Health Center, which includes but not limited to situations of psychiatric emergency. I will be responsible for all related expenses or charges not covered by my personal health insurance provided to Valparaiso University Student Health Center at the time services rendered. I affirm that the information present on this Health Form is complete and accurate to the best of my knowledge.

Student’s Signature: ___________________________  Parent/guardian’s Signature (If student is under 18 years of age): ___________________________  Date: ______________________

**PART VI: TREATMENT/SHARING OF MEDICAL INFORMATION OF MINORS**

As the parent/guardian of my minor (under 18 years of age) son or daughter, in pursuant to Indiana Code Paragraph 16-36-1-6 and subject to any limitations listed below, I request and authorize:

1) The sharing/exchange of relevant medical information between Valparaiso University Student Health Center representatives for the purpose of diagnosis and/or treatment with other medical providers. Each of the above individuals or entities is also authorized to communicate and discuss health matters with the parents/guardians/emergency contacts of my minor child.
2) The transportation of my minor child, under appropriate circumstances, to area hospitals for diagnosis and treatment.
3) The provision, by the Valparaiso University Student Health Center, of such diagnostic, therapeutic, voluntary immunization, and minor procedures as may be deemed necessary for my minor child. In my absence, my child may sign on their behalf for treatment and method of payment for each visit rendered at the Student Health Center.

Any and all related expenses will be the responsibility of the child and/or parent/guardian after filing the personal health insurance provided to the University.

Parent/guardian’s Signature: ___________________________  Relationship: ___________________________  Date: ______________________

Student’s Signature: ___________________________  Date: ______________________

PAGE 4  Valparaiso University Student Health Center | 55 University Drive Suite 102, Valparaiso, IN 46383 | Phone: 219.464.5060 | Fax: 219.464.5410 04/2017